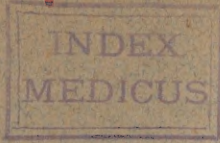


MANTON (W.P.)



On the Management of the Third Stage of Labor
and its Relation to Post-Partum
Hemorrhage.

BY

W. P. MANTON, M. D.,

DETROIT,

President Detroit Academy of Medicine.



REPRINTED FROM

The American Gynecological Journal, Toledo, O.,

JUNE, 1892

ON THE MANAGEMENT OF THE THIRD STAGE OF LABOR AND ITS RELATION TO POST-PARTUM HEMORRHAGE.¹

BY W. P. MANTON, M. D., DETROIT, PRESIDENT DETROIT ACADEMY OF
MEDICINE.

“There is a wisdom in this beyond the rules of physic; a man’s own observation, what he finds good of and what he finds hurt of, is the best physic to preserve health.

“Therefore, since custom is the principal magistrate of a man’s life, let men by all means endeavor to obtain good customs.”—BACON.²

If modern researches in obstetrics have taught us anything, they have taught us that pathological manifestations arising during the puerperium are largely dependent upon antecedent causes which for the most part are preventable; that if child-bed is to be normal, pregnancy, and especially labor, must be guarded against the invasion of conditions which in the lying-in state may develop into disease. This has, to an extent, always been recognized, but the older observers were baffled in their seeking after truth, because of the unknown quantity separating cause and effect, and hence arose their bitter cry of defeat, the irony of despair, “meddlesome midwifery.”

It was not until theory, experiment and practice had met on common ground, and with the scalpel, the microscope and the culture tube discovered and demonstrated the sources of evil, that the reason for failure in the past became evident; cause and effect were portrayed in their true relationship, and the new practice evolved.

The changes which have taken place in obstetric methods during the past forty years are, perhaps, nowhere better exemplified than in the third stage of labor. One reads with a certain mental refreshment of the naive manner in which Smellie and contemporaneous writers advise entering the parturient canal with the hand for the removal of the secundines; of “puking” the patient to excite uterine contractions and increase abdominal pressure; of bleeding the flooding parturient to check the hemorrhage, and many kindred methods formerly employed. It is no wonder that the recoil came, and men said “meddlesome midwifery,” and became do-nothings, leaving to nature that which misapplied art had failed to successfully accomplish.

1. Read before the Michigan State Medical Society, May 5th, 1892.

2. Anderson’s edition, pages 167 and 201



But that wise old man and keen observer, Sir Thomas Browne, remarks in his *Religio Medici* that nature is not at variance with art, art is the perfection of nature; and art I interpret, in this instance, to mean the judicious application of means which will assist, not retard or antagonize nature.

The two conditions following placental casting which the obstetrician has most to fear are hemorrhage and septic infection. Our knowledge of the sources of the latter, and the means of certain prophylaxis at hand, should make this, as compared with half a century ago, one of the rarest of affections; while the method of placental delivery now almost universally in vogue, together with uterine control, should also place hemorrhage upon the same list.

But, unfortunately, while the accoucheur may practice his art with the utmost cleanliness, he is liable to neglect that watchful oversight of the uterus which the majority of cases demand; a neglect which is proved to my mind by the frequent reports of cases of post-partum hemorrhage to be found in current literature.

Hemorrhage from the uterus following delivery may result from three causes:

First.—An atonic state of the organ or a portion of its walls (placental site, etc.).

Second.—Traumatic lesions produced during delivery.

Third.—Displacement of the uterus—chiefly partial introcession, with which latter must also be included the first cause.

The two latter conditions are of such comparative infrequency, most cases of post-partum hemorrhage being dependent upon the first cause, that I shall confine myself to the discussion of this etiological moment.

As soon as the child is expelled from the vagina a period of uterine inaction ensues, which may last for from five to fifteen or more minutes. During this period, if let alone, that is, if all friction, rubbing and kneading of the abdomen are omitted, the uterus rises from behind the pubes, sometimes attaining to the elevation of the umbilicus. A series of contractions then begin, and the patient exhibits a tendency to bear down, feeling that a foreign body is still in the womb, of which she must rid herself. The design, if carried out, soon forces the placenta into the vagina, and then to the vulva, and the act is completed.

This would be nature's method were nature competent to carry out what is put upon her; but, unfortunately, this is achieved by her unaided in only about twenty-five per cent. of cases (Zinnstag),³ leaving the remaining seventy-five per cent. to be dealt with by other means.

Now, it is during the period of relaxation that active hemorrhage frequently begins, a hemorrhage which externally may appear to be but

3. Archiv f. Gynakologie, Bn. xxxiv., p. 255.

slight, the blood remaining concealed within the uterus, either behind the placenta or within the membranes, so that if expression be finally resorted to, in the words of Zinnstag, the obstetrician is "astonished to expel with the first compression an alarming amount of coagulated blood."

Undue loss of blood during labor, we all know, has a retarding effect upon puerperal convalescence, so that the less the hemorrhage the stronger the patient, and the quicker the restoration of the organs concerned in reproduction to their non-parous condition.

It is plain, therefore, that the duty of the accoucheur is to prevent too great uterine relaxation before the placenta is delivered, to accomplish which he must either follow the diminishing uterus with the hand upon the abdomen during the birth of the child, or by gentle friction stimulate it to prompt contraction as soon as the infant is born;—the former method being a surer preventive of blood loss. During the period of rest, the hand, still upon the abdomen, holds the uterus in check, and as soon as the pains are again established—according to Credè, not before the fourth contraction, which takes place in from ten to fifteen minutes—gently expresses the placental cake.

Those who practice the expectant method of placental delivery wait for one and one-half hours before disturbing the uterus (Ahlfeld). But, as has been stated, if in only one-fourth of all cases the parturient organs are competent to accomplish placental expulsion after waiting this length of time or longer, and some means of getting rid of the mass must eventually be brought into play with the remaining three-fourths, what good reason is there in any instance for delaying longer than the time prescribed by Credè? And does not the patient herself appeal in every way for more prompt action, and an end to her sufferings? Cohn⁴ has shown that uterine contractions may force the cake into the lower uterine segment, but that there their function is fulfilled, the abdominal muscles then taking up and completing the expulsion. But the pressure of these muscles is decidedly deficient in the great majority of women, and if some manipulation on the part of the physician is not put into practice the placenta may remain in the lower uterine segment for a very considerable length of time. Von Campe⁵ found from experiments in Winckle's clinic that the placenta may be retained in utero for more than fifty hours without sufficient energy being exerted by the organism to get rid of it.

That the idea of the inefficiency of the abdominal muscles is not confined to civilized peoples is well exemplified by the use of the squaw belt among certain tribes of North American Indians, the Mexican belly-squeezing,⁶ and numerous other methods practiced by savages in all parts of the world.

4. Zeitschrift f. Geburtshulfe und Gynakologie, Bd. xii., p. 381.

5. Winckel's Lehrbuch der Geburtshulfe.

6. See Engelmann, Labor Among Primitive People, and Ploss, Ueber die Lage und Stellung der Frau Walwend der Geburt bei Verschiedener Völkern.

No one will deny that undue haste in placental delivery is also an error, but the method of Credè, if practiced as described, cannot be assailed with this imputation. In referring to some 556 primiparous cases, of which I have notes, I find that placental expression was employed as follows:

Immediately,	-	-	-	-	79 times.
In 5 minutes,	-	-	-	-	87 times.
In 10 minutes,	-	-	-	-	289 times.
In 15 minutes,	-	-	-	-	74 times.
In 20 minutes,	-	-	-	-	3 times.
In 25 minutes,	-	-	-	-	1 time.
In 30 minutes,	-	-	-	-	8 times.
In 90 minutes,	-	-	-	-	1 time.
Time not given,	-	-	-	-	14 times.
Total,	-	-	-	-	556 ⁷

In the entire number of cases post-partum hemorrhage is noted as having occurred but twice.

But while the dangers from hemorrhage are great prior to placental delivery, the most frequent period for their occurrence is soon after that "fœtal lung" has been expelled. How often do we read of the case which the physician has left in comparative comfort and well-being, suddenly developing all the symptoms of acute anæmia, with the life-blood gushing from the relaxed uterus.

According to the classification of Barker, post-partum hemorrhage is "primary" when occurring within the first six hours after delivery; and "secondary" from that time to the end of puerpery. Secondary hemorrhage, occurring after a well-conducted labor, is a condition for which no physician should be responsible. It may result from such a great variety of unforeseen causes that to perfectly guard against its occurrence is well nigh impossible. But primary hemorrhage is, I believe, quite within the power of the accoucheur to prevent, and he indeed is guilty of gross neglect who loses a case or retards his patient's convalescence by so unfortunate an accident. I have elsewhere⁸ presented my views upon this subject, but it may be stated here that I believe, and my conclusions are founded upon a pretty considerable experience, that if the uterus is well controlled by the hand during the hour succeeding the expulsion of the after-birth, primary post-partum hemorrhage will be one of the most infrequent of obstetrical casualties.

83 Lafayette Ave.

7. In one case of 5 minutes, one of 10, and those of 30 and 90 minutes, the placenta was removed manually.

8. Manton, On the After Treatment of Normal Midwifery Cases.—[Transactions of the Detroit Medical and Library Association, 1891.

